

Case Number:	CM13-0048523		
Date Assigned:	12/27/2013	Date of Injury:	05/20/2013
Decision Date:	05/23/2014	UR Denial Date:	10/28/2013
Priority:	Standard	Application Received:	11/06/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

██████████ is a 19-year-old woman who sustained a work-related injury on May 20, 2013. She subsequently developed chronic left knee pain. She underwent left knee ACL reconstruction on July 27 2013. According to a note dated on October 14 2013, the patient was complaining of dull left knee pain. An MRI of the left knee performed on October 10 2013 demonstrated that the ALC graft is intact and irregularity of the medial meniscus. Her provider requested authorization for repeat left knee arthroscopy.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

REPEAT LEFT KNEE ARTHROSCOPY WITH DEBRIDEMENT AND MENISCECTOMY AS NEEDED AT ██████████: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 347.

Decision rationale: According to MTUS guidelines, meniscectomy is indicated for a severe mechanical sings or serious activity limitation and MRI of the knee supporting meniscal damage. The patient MRI does not clearly support meniscal damage. Therefore the request for repeat left

knee arthroscopy with debridement and meniscectomy as needed at [REDACTED] is not medically necessary.

PRE- OPERATIVE EKG, CXR, CBC, CMP, UA, PTT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 347. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Cold/Heat Packs

Decision rationale: Because the left knee arthroscopy was not approved, there is no need for pre-op work up. The pre-operative EKG, CXR, CBC, CMP, UA, PTT is not medically necessary.

COLD THERAPY UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 347. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Cold/Heat Packs.

Decision rationale: According to ODG guidelines, cold therapy is Recommended as an option for acute pain. At-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. (Bigos, 1999) (Airaksinen, 2003) (Bleakley, 2004) (Hubbard, 2004) Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. (Nadler 2003) The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. (French-Cochrane, 2006) There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. (Kinkade, 2007) See also Heat therapy; Biofreeze® cryotherapy gel

NORCO 10/325 MG: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids Page(s): 179.

Decision rationale: Because the left knee arthroscopy was approved, there is no need for Norco to treat post op pain. The request for Norco 10/325 mg is not medically necessary.

POST OPERATIVE PHYSICAL THERAPY 2X6: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 347.

Decision rationale: Because the left knee arthroscopy was not approved, there is no need for post op physical therapy. The post operative physical therapy 2X6 is not medically necessary.